HELP

Complete and use the button at the end to print for mailing.

CRIME VICTIMS' COMPENSATION APPLICATION

SOUTH DAKOTA CRIME VICTIMS' COMPENSATION PROGRAM
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF ADULT SERVICES & AGING
700 GOVERNORS DRIVE
PIERRE, SOUTH DAKOTA 57501-2291
(605) 773-6317
1-800-696-9476

SOUTH DAKOTA CRIME VICTIMS' COMPENSATION PROGRAM
South Dakota Department of Social Services, Office of Adult Services & Aging
700 Governors Drive
Pierre, S.D. 57501-2291
(605) 773-6317
1-800-696-9476
Web address: www.state.sd.us/social/cvc

Application Instructions

Complete the W-9 form on the back if applying for reimbursement or lost wages.

1. Please type or print clearly.
2. If sufficient space is not provided on this form, use additional sheets as necessary.
3. If you need any help in completing the application, call the number above.
4. Attach all medical, hospital and/or funeral bills that you have received and that apply to this request for compensation or provide the names, addresses and telephone numbers for all providers.
5. The application MUST be signed by the victim, or the parent or guardian if the victim is under 18 years of age. In the event of the death of a victim, the application may be signed by a survivor or a person authorized to administer the victim's estate.
6. IN THE EVENT OF THE DEATH OF THE VICTIM, BE SURE TO FILL OUT **SECTION XI-BENEFICIARY/FUNERAL**. The maximum amount that may be awarded for funeral and burial expenses is $6500.00 including up to $1200.00 for a headstone and up to $500.00 for miscellaneous expenses.
7. Up to $1,000 may be awarded under extraordinary circumstances for emergency expenses resulting from the crime. To request an emergency payment, call the above number after you have filed this application. Any emergency payment must be deducted from the final award.
8. The maximum amount that may be awarded for each victim of a crime is $15,000.
9. You must notify us of any change in your address or telephone number.
10. If you do not know the answer to any question write "unknown".
11. The Application MUST contain a brief description of the crime (see Section VI).

A person **may be** eligible for compensation if:

- He/she has been the victim of or witness to a violent crime which resulted in personal injury or death or he/she is the parent of a child abuse victim, a spouse of a rape victim or a family member of a homicide victim.
- The injury occurred as result of a crime, trying to apprehend a person committing a crime, trying to help a law enforcement officer, or trying to prevent a crime.
- An application was filed within (1) year of the incident, except for good cause. If you are filing past 12 months, please submit a letter stating the reason for the delay.
- The victim did not cause or contribute to the injury or death and was not committing a crime.
- The incident was reported to law enforcement within (5) days of when it could reasonably have been reported, and the victim reasonably cooperated with law enforcement personnel. If the crime was not reported within 5 days of the date that it occurred or if the victim did not fully cooperate, please submit a letter explaining the reason for the delay or decision not to cooperate.
- The compensation will not unjustly benefit the offender or an accomplice.

THE CRIME MUST HAVE OCCURRED AFTER JUNE 30,1992.

South Dakota
Crime Victims' Compensation
Application

You must fill out every applicable section completely to have your claim processed

RETURN TO:
Department of Social Services
Office of Adult Services & Aging
700 Governors Drive
Pierre, S.D. 57501-2291

DO NOT WRITE IN THIS SPACE

CLAIM#_____

DATE RECEIVED_____

PLEASE READ INSTRUCTIONS BEFORE BEGINNING

SECTION I. General Claim Information

You are filing this application because you are/were (check one):

1. ☐ The victim of a crime.
2. ☐ Trying to help a crime victim or police officer.
3. ☐ Trying to prevent a crime or apprehend a criminal.
4. ☐ The parent/guardian of a crime victim under the age of 18.
5. ☐ The guardian of a crime victim who is incompetent.
6. ☐ The dependent of a crime victim.
7. ☐ The person administrating the victim's estate.

SECTION II. Victim Information

Victim's Name:_____ Soc. Sec. No. _____

Date of Birth:_____ Age:_____ ☐ Male ☐ Female ☐ Marital Status
☐ M ☐ S ☐ Sp ☐ D ☐ W

Mailing Address:_____
street city state zip code county

Telephone: (home) _____ (work) _____

THE DEPARTMENT OF JUSTICE IS REQUIRED TO COLLECT THE FOLLOWING INFORMATION ABOUT THE VICTIM

SECTION III.

1a. RACE: ☐ Caucasian ☐ Hispanic ☐ Black ☐ Other

☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander

1b. NATIONAL ORIGIN: USA ☐ Yes ☐ No Other _____

2. WERE YOU HANDICAPPED BEFORE THIS CRIME OCCURRED? ☐ Yes ☐ No Explain:
_____

3. ARE YOU HANDICAPPED AS A RESULT OF THIS CRIME? ☐ Yes ☐ No Explain:
_____

4. Are you a South Dakota resident? ☐ Yes ☐ No
5. Was the crime a federal offense? ☐ Yes ☐ No ☐ Unknown

SECTION IV. Claimant Information (if someone other than the victim is filing the claim.)

If you checked 4,5,6 or 7 in Section I above, please complete this section.

Your Name:_____ Relationship to Victim: _____

Date of Birth:_____ Soc. Sec. No. _____

Mailing Address _____
street city state zip code

Telephone: (home) _____ (work) _____

SECTION V. I learned about this program from (check one)

☐ Prosecuting Attorney ☐ Hospital, Doctor, etc. ☐ Brochure/Poster ☐ News Media
☐ Non-profit Service Agent ☐ Family Violence Shelter ☐ Relative/Friend ☐ Welfare
☐ Counselor/Therapist ☐ Law Enforcement ☐ Victim Witness Program
☐ Other_____

SECTION VI. Crime (Note: The crime must have occurred after June 30, 1992.)

Location of Crime:_____
street address city/county
Date of Crime:_____ Crime reported to:_____ Date:_____

Who committed the crime?_____ Law enforcement case#:_____

☐Yes ☐No Victim knew the offender? If yes, in what way? _____

☐Yes ☐No Victim was related to the offender? If yes, how? _____

☐Yes ☐No Was victim living in same house as the offender? If yes, is victim still living in same house as the offender ? ☐Yes ☐No

☐Yes ☐No Has the offender been charged in court?

☐Yes ☐No Was the offender ordered to pay restitution?
Amount ordered:_____ Amount received: _____

☐Yes ☐No Is the victim or claimant considering a civil action?
Name and address of attorney handling civil action: _____
_____

Briefly describe the crime and the injuries that you incurred. Attach additional sheets if necessary:

SECTION VII. Insurance or Benefits From Other Sources

Do you have coverage or are you entitled to benefits from any of the following:

Source	Yes	No	Identify contact person and phone number, address and policy/case number
Health Insurance	☐	☐	_____
Auto Insurance	☐	☐	_____
Public Assistance	☐	☐	_____
Medicaid	☐	☐	_____
Medicare	☐	☐	_____
Social Security	☐	☐	_____
Worker's Compensation	☐	☐	_____
Veterans' Administration	☐	☐	_____
Indian Health Service	☐	☐	_____
Other	☐	☐	_____

SECTION VIII. PARTICULARS OF MEDICAL BILLS
(Attach additional sheets if necessary)

Name & Address	Amount of Bill to Date	Amount Paid by Victim/Claimant	Amount Paid By Others	Balance
Hospital				
Doctors				
Counseling				
Dentist				
Optician				
Ambulance				
Others				

Will there be more bills? ☐Yes ☐No If so, for what? _____

IF AVAILABLE, ATTACH COPIES OF ALL BILLS, RECEIPTS AND INSURANCE BENEFITS STATEMENTS.

SECTION IX. Employment and Earnings Information

Does the victim want compensation for lost wages? ☐Yes ☐No
(If yes, we will contact the employer(s) to confirm the amounts claimed.)
(Note: The maximum amount that may be paid for lost wages is the Federal minimum wage x 40 hours.)
Was the victim employed at the time of the injury? ☐Yes ☐No
If yes, complete the following. If **Self Employed** include copy of most recent Federal Income Tax return.
Employer_____ Contact Person _____
Address: _____
street city state zip code
Telephone: _____ Weekly wage before deductions $_____
Provide above information for all employers during the 6 months prior to the crime.
Did the victim miss any time from work because of injuries from the crime? ☐Yes ☐No
If yes, please complete the following: _____weeks _____days, from (dates)_____ to _____
Has the victim returned to work? ☐Yes ☐No If yes, when?_____
Did the victim's wage continue while off work? ☐Yes ☐No If yes, complete the following:

Source (Check)	Amount per week	From (date) to (date)
☐ Worker's Comp		
☐ Unemployment Comp		
☐ Health Plan		
☐ Vacation or Sick Leave		
☐ Disability Pay		
☐ Other, Specify		

Did or does the victim have income from any of these sources?

Source	Amount/Month	Source	Amount/Month
☐ Social Security	$_____	☐ Social Security Dis.	$_____
☐ General Assist.	$_____	☐ Welfare	$_____
☐ T.A.N.F.	$_____	☐ Other, Specify	$_____

If the victim was not employed or receiving assistance at the time of injury, please tell us the victim's source of income:_____

SECTION X. Beneficiary/Funeral:

(Note: If the victim died as a result of the crime, please complete the following.)
Date of Death_____ (attach copy of Certificate of Death.)
At the time of death, did the victim contribute financial support for any dependent(s)? ☐ Yes ☐ No
If yes, amount/month $_____
(Attach documentation of amount such as a paystub, tax return or name and address of employer.)

LIST DEPENDENTS OF THE VICTIM

_____
Name (last) (first) (middle) Sex Date of Birth

_____
address/street city state zip Relationship to Victim

_____
Name (last) (first) (middle) Sex Date of Birth

_____
address/street city state zip Relationship to Victim

Did the victim have life or burial insurance? ☐ Yes ☐ No If yes, complete the following:

	Name and Address of Company	Amount	Policy Number
1.	_____	$_____	$_____
2.	_____	$_____	$_____

Will the dependent(s) receive benefits from the following? ☐ Yes ☐ No If yes, complete the following:

☐ Social Security	$_____	☐ Worker's Compensation	$_____
☐ Life Insurance	$_____	☐ Public Assistance	$_____
☐ Tribal Fund	$_____	☐ Other	$_____

Name of funeral home_____ Address_____
Amount of funeral and burial expenses: $_____ Have expenses been paid? ☐ Yes ☐ No
If yes, by whom? Name_____ Address_____
Telephone _____ (Attach copies of bills; if paid, attach proof of payment)

SECTION XI. Homemaker/Childcare Replacement

Indicate how many _____weeks _____days replacement homemaker or childcare services were needed.
Name and address of persons providing services (attach all available receipts).

_____
name address/street

_____
city state zip telephone (home) (work)
Total cost of replacement services $_____ Type(s) of services:_____
Reason(s) why services were required_____
Amount paid by victim/claimant $_____ Balance Due $_____

SECTION XII. Other Expenses or Losses (attach receipts or estimates)

Description(s):_____ Total cost/loss:_____

Total paid by victim/claimant:_____ Total paid by others (identify)_____

DECLARATION AND AUTHORIZATION

I declare and affirm under the penalties of perjury that the application has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

If I am awarded compensation, I promise to repay the State of South Dakota Crime Victims' Compensation Program for any payments received from the person who committed this crime, whether from restitution or civil action, or from any insurance company, or any other governmental or private agency, which payments are for any injury or loss included in my claim. Further, I promise to give my written notice to the Crime Victims' Compensation Program if I pursue a claim or demand or if I file a lawsuit for the damages sustained.

I authorize and request any person having information necessary to the administration of my claim, including all past law enforcement records concerning me, to release that information to the Crime Victims' Compensation Program, South Dakota Department of Social Services. This release includes, but is not limited to, private and governmental physicians, hospitals, clinics, ambulance services, past and present employers, and any private company or governmental agency which is providing, or may provide, medical or monetary benefits. I agree and certify that no person shall incur any legal liability to me by releasing any information pursuant to this authorization. A photocopy of this authorization shall have the same effect as the original.

Signature_____

Print Name _____

Dated this _____day of _____, 20 ___

Form **W-9**
(Rev. January 2003)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type See **Specific Instructions** on page 2.

Name

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ► ---------- ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). **However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3.** For other entities, it is your employer identification number (EIN). If you do not have a number, see **How to get a TIN** on page 3.

Note: *If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.*

Social security number
___ ___ ___ – ___ ___ – ___ ___ ___ ___

or

Employer identification number
___ ___ – ___ ___ ___ ___ ___ ___ ___

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding, **and**
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item **2** above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item **2** does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here **Signature of U.S. person ►** **Date ►**

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee.

Note: *If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

Foreign person. If you are a foreign person, use the appropriate Form W-8 (see **Pub. 515,** Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

1. PRINT FOR MAILING CLEAR FORM